

CLINICAL PRIVILEGES – MENTAL HEALTH PROVIDERS

AUTHORITY: Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.

PRINCIPAL PURPOSE: To define the scope and limits of practice for individual providers. Privileges are based on evaluation of the individual's credentials and performance.

ROUTINE USE: Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from the Air Force.

DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges.

INSTRUCTIONS

APPLICANT: In Part I, enter Code 1, 2, or 4 in each REQUESTED block for every privilege listed. This is to reflect current capability and should not consider any known facility limitations. Sign and date the form. Forward the form to your Clinical Supervisor. *(Make all entries in ink.)*

CLINICAL SUPERVISOR: In Part I, using the facility master privileges list, enter Code 1, 2, 3, or 4 in each VERIFIED block in answer to each requested privilege. In Part II, check appropriate block either to recommend approval, to recommend approval with modification, or to recommend disapproval. Sign and date the form. Forward the form to the Credentials Function. *(Make all entries in ink.)*

CODES:

1. Fully competent within defined scope of practice. *(Clinical oversight of some allied health providers is required as defined in AFI 44-119.)*
2. Supervision required. *(Unlicensed/uncertified or lacks current relevant clinical experience.)*
3. Not approved due to lack of facility support. *(Reference facility master privileges list.)*
4. Not requested/not approved due to lack of expertise or proficiency, or due to physical disability or limitation.

CHANGES: Any change to a verified/approved privileges list must be made in accordance with AFI 44-119.

NAME OF APPLICANT *(Last, First, Middle Initial)*

NAME OF MEDICAL FACILITY

I. LIST OF CLINICAL PRIVILEGES – MENTAL HEALTH PROVIDERS

Requested	Verified	
		A. PSYCHIATRIST
		1. Evaluation
		a. Conduct clinical interview
		b. Diagnose mental disorders and formulate treatment/dispositional plans and recommendations
		2. Admit patients to hospital
		3. Procedures
		a. Electroconvulsive therapy
		b. Amytal or benzodiazepine interview
		4. Therapies
		a. Psychotherapy
		b. Group psychotherapy
		c. Chemotherapy
		5. Procedures requiring additional training or requirements
		a. Hypnosis for evaluation and therapy ¹
		b. Formal sex therapy ²
		c. Biofeedback ²
		6. Other <i>(Specify)</i>
		a.
		b.
		B. CLINICAL PSYCHOLOGIST
		1. Evaluation
		a. Conduct clinical interview and psychological procedures
		b. Diagnose mental disorders and formulate treatment/dispositional plans and recommendations
		c. Recommend administrative and medical dispositions
		d. Neuropsychological screening
		e. Neuropsychological assessment/evaluation ³
		2. Admit/treat/discharge patients to/from inpatient mental health facility with physician participation for physical assessment
		a. Admit/treat/discharge patients to/from psychiatric unit
		b. Admit/treat/discharge patients to/from substance abuse rehabilitation/treatment program
		3. Hypnosis for evaluation and therapy ¹
		4. Therapies
		a. Psychotherapy
		b. Group psychotherapy
		c. Formal sex therapy ²
		d. Biofeedback ²

(NOTE: ¹ Must meet requirements and recommendations for the American Society for Clinical Hypnosis or the Society for Clinical and Experimental Hypnosis

² Must demonstrate acceptable training and experience according to AFI 44-119

³ Must have a 42P34 AFSC (Clinical Psychologist with Neuropsychology shred out))

I. LIST OF CLINICAL PRIVILEGES – MENTAL HEALTH PROVIDERS <i>(Continued)</i>		
Requested	Verified	
		B. CLINICAL PSYCHOLOGIST (continued)
		5. Other <i>(Specify)</i>
		a.
		b.
		C. CLINICAL SOCIAL WORKER
		1. Evaluation
		a. Conduct clinical interview
		b. Diagnose mental disorders and formulate treatment/dispositional plans and recommendations
		c. Recommend administrative and medical dispositions
		2. Admit patients to substance abuse rehabilitation/treatment program
		3. Hypnosis for evaluation and therapy ¹
		4. Therapies
		a. Psychotherapy
		b. Group psychotherapy
		c. Formal sex therapy ²
		d. Biofeedback ²
		5. Other <i>(Specify)</i>
		a.
		b.
<small>(NOTE: ¹Must meet requirements and recommendations for the American Society for Clinical Hypnosis or the Society for Clinical and Experimental Hypnosis ²Must demonstrate acceptable training and experience according to AFI 44-119 ³Must have a 42P34 AFSC (Clinical Psychologist with Neuropsychology shred out!))</small>		
SIGNATURE OF APPLICANT		DATE
II. CLINICAL SUPERVISOR'S RECOMMENDATION		
<div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <input type="checkbox"/> RECOMMEND APPROVAL <input type="checkbox"/> RECOMMEND APPROVAL WITH MODIFICATION <i>(Specify below)</i> <input type="checkbox"/> RECOMMEND DISAPPROVAL <i>(Specify below)</i> </div> <div style="height: 300px; border: 1px solid black;"></div>		
SIGNATURE OF CLINICAL SUPERVISOR (Include typed, printed, or stamped signature block)		DATE